MEDICARE FINANCING CRISIS: RECOMMENDATIONS OF THE ADVISORY COUNCIL ON SOCIAL SECURITY

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

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CONTENTS

	Page
Press release of Monday, March 26, 1984, announcing hearing	1
Witnesses:	
Advisory Council on Social Security:	
Hon. Otis R. Bowen, M.D., Chairperson (former Governor of Indiana), and Thomas R. Burke, Executive Director	2
Stanford Arnold, member (secretary-treasurer, Michigan Building & Construction Trades Council)	8

MEDICARE FINANCING CRISIS: RECOMMENDATIONS OF THE ADVISORY COUNCIL ON SOCIAL SECURITY

FRIDAY, MARCH 30, 1984

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met at 10:15 a.m., pursuant to notice, in room 1100, Longworth House Office Building, Hon. Andy Jacobs, Jr. (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

[Press release of Monday, Mar. 26, 1984]

THE HONORABLE ANDY JACOBS, JR., (D., IND.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, ANNOUNCES A SERIES OF HEARINGS ON THE MEDICARE FINANCING CRISIS AND THE RECOMMENDATIONS OF THE ADVISORY COUNCIL ON SOCIAL SECURITY

The Honorable Andy Jacobs, Jr. (D., Ind.), Chairman of the Subcommittee on Health of the Committee on Ways and Means, U.S. House of Representatives, announced today the first in a series of hearings by the Subcommittee on the medicare financing crisis and possible solutions. The first day's hearing will be on the recommendations for changes in the medicare program made by the Advisory Council on Social Security contained in the Council's recently submitted final report. This first in the series of hearings will be held on Friday, March 30, 1984, in Room 1100, Longworth House Office Building, beginning at 10:00 a.m.

Scheduled witnesses from the Advisory Council on Social Security will include its Chairman, former Indiana Governor Otis R. Bowen, M.D., and Mr. Stanford D. Arnold.

It is expected that during additional days of hearings (the dates of which will be announced by a future press release), the Subcommittee will receive testimony from public witnesses wishing to comment on the recommendations of the Advisory Council on Social Security, reports on the most current estimates of the financial status of the medicare trust funds and alternative proposals for responding to the problems of rising health care costs and diminishing medicare trust fund reserves.

Among the proposals on which the Committee anticipates hearing testimony during subsequent days of the hearing is H.R. 4870, the "Medicare Solvency and Health Care Financing Reform Act of 1984," introduced by the Honorable Richard A. Gephardt (D., Mo.). (A companion bill, S. 2424, was introduced in the Senate by the Honorable Edward M. Kennedy (D., Mass.))

In addition, the Subcommittee anticipates receiving testimony on a variety of other proposals and recommendations addressing the medicare financing crisis, proposing health care cost control or reform of the health care system, such as H.R. 3884, the "Health Service Act," introduced by the Honorable Ronald V. Dellums (D., Calif.).

Background information

Medicare financing problem: The medicare program is facing serious financial problems. The latest estimates from the Congressional Budget Office (CBO) project

depletion of the Hospital Insurance Trust Fund by the end of the decade, and rapidly growing cumulative deficits after that. While the Supplementary Medical Insurance Trust Fund does not face the prospect of depletion because of automatic transfers from general revenues, these transfers are large and growing rapidly. Moreover, these transfers increase the size of the Federal deficit.

In November of 1983, the Committee, in conjunction with the Congressional Budget Office and the Congressional Research Service of the Library of Congress sponsored a two-day Conference on the Future of Medicare at which the authors of commissioned papers and a large group of discussants from various disciplines and backgrounds explored the nature of the financing problem and options for solution. At the conference, CBO characterized the problem as a manifestation of a broader societal problem—the vastly different growth rates between health care spending and the incomes available to pay for it. Options suggested for solving the problem include some combination of the following: paying for fewer services through volume controls; paying less for services through reimbursement controls; and shifting responsibility to beneficiaries through cost sharing or premium changes, or to taxpayers through revenue increases. Other options would attempt to solve the problem through cost control or reform of the health care system generally.

Advisory Council on Social Security: Under law, an Advisory Council on Social Security is to be appointed every four years by the Secretary of Health and Human Services. The current Council, appointed in September of 1982, was directed to concentrate exclusively on the medicare program and its financing rather than on the old-age, survivors and disability insurance system, because a specially created National Commission on Social Security had recently been appointed to study and make recommendations on that system. The Advisory Council's report indicates that its objectives were (1) to provide a means for maintaining the fiscal integrity of the medicare hospital insurance trust fund through 1995, and (2) to provide improvements in the manner in which health care is financed and delivered which will alleviate some of the financial pressures on the trust fund in the future.

For the March 30 day of hearings, the Subcommittee will receive testimony only from invited witnesses representing the Advisory Council on Social Security. A future press release will invite members of the public to submit their requests to be heard during future hearing days on the Advisory Council recommendations and other issues related to medicare financing and health system reform.

Chairman JACOBS. The Subcommittee on Health of the House Ways and Means Committee is now in order.

Our hearing is for the purpose of receiving testimony from the Advisory Council on Social Security regarding their recommendations. We are especially pleased and honored to have the testimony of the Honorable Otis R. Bowen, M.D., Chairperson, former Governor of Indiana, former Speaker of the House of Representatives of Indiana, and all-around nice guy.

Doctor, if you will proceed in your own fashion. The 5-minute rule does not apply in your case. We can't get enough of you.

STATEMENT OF OTIS R. BOWEN, M.D., CHAIRPERSON, AVISORY COUNCIL ON SOCIAL SECURITY, FORMER GOVERNOR OF INDIANA, ACCOMPANIED BY THOMAS R. BURKE, EXECUTIVE DIRECTOR OF THE ADVISORY COUNCIL

Dr. BOWEN. Thank you very much, Mr. Chairman, and members of the Subcommittee on Health. I am Otis Bowen, former Governor of Indiana and Chairman of the Advisory Council on Social Security. I am delighted to be here to offer testimony before my own Congressman, Andy Jacobs. I think you forgot to say that.

I am from your district. I am accompanied today by Mr. Stanford Arnold, who will present the minority position of the Council, and Mr. Thomas Burke.

I am here to report on the findings and recommendations of the Council. With your permission, Mr. Chairman, I shall try to keep my prepared remarks brief in order to conserve time and allow for

questions you may have regarding one or more of the several recommendations that the Council is proposing.

Medicare is the Nation's largest federally financed health insurance program serving approximately 30 million elderly and disabled Americans. One of the most successful social programs, it has provided basic protection against the costs of health care for a significant portion of the population.

However, the continued escalation of health care costs and an increasing elderly population have placed extraordinary demands on the program and its resources that were not anticipated when the program began in 1966. If we are to ensure that medicare will continue to meet the needs of our elderly and disabled citizens, prompt action is required to restore its financial position.

When the Advisory Council on Social Security was appointed in September of 1982 by the then Secretary of Health and Human Services, Richard Schweiker, it was directed by its charter to place particular emphasis on a review of the medicare program.

The Council took its charter very seriously devoting more than a year to intensive deliberations, involving 14 meetings and 8 public hearings. Our public hearings were held in cities throughout the United States, including San Francisco, Evanston, IL, St. Petersburg, FL, and New Brunswick, NJ.

The Council has developed a series of recommendations that we believe will both alleviate the financial problems currently confronting the program and improve its responsiveness to the needs of program beneficiaries.

The Council is making 26 different recommendations. We operated under a considerable time constraint and were not able to address every health care issue that probably should have been addressed.

We have, nonetheless, come up with a plan for rescuing the financially burdened medicare program. I am not here today to say that this is a perfect plan or the only plan, but I do believe we have provided an agenda that I hope you, as Members of Congress, will seriously consider as you address this important national issue.

We have undertaken extensive staff work which we believe should be of assistance to your staff in tackling this problem, a problem we know is very quickly going to confront the entire country, particularly the elderly and disabled Americans who are served by the medicare program.

To put the problem in perspective, the Council adopted a working assumption that the hospital insurance trust fund would experience a cumulative deficit of $200 to $300 billion by the end of 1995. This estimate was based on information provided by the 1983 annual report of the medicare board of trustees, estimates issued by the Congressional Budget Office and additional information provided by the Health Care Financing Administration's Office of Financial and Actuarial Analysis.

Although some recent estimates indicate that the point of insolvency may be delayed a few years, the timeframe in which action is necessary is already close at hand.

The Council recommendations are categorized into six general areas—financing, eligibility, benefit structure, reimbursement, issues general in nature and issues deserving further study. Let me

now highlight some of the more significant recommendations of the Council.

In addressing the benefit structure of the medicare program, the Council's principal objectives were to provide improved catastrophic protection for all beneficiaries; to simplify, as much as possible, the benefit package; to incorporate reasonable cost-sharing by beneficiaries; to identify ways to alleviate the financial crisis facing the hospital insurance trust fund.

We believe that our recommended restructured benefit package will accomplish these objectives and will do so by using traditional health insurance concepts that spread the risk and liability for increased costs across all beneficiaries who will be eligible for the improved benefits recommended.

We reviewed a variety of cost-sharing approaches that provided for increased coinsurance during shorter more typical hospital inpatient stays to finance improved catastrophic protection and produce savings for the trust fund.

Our major problem with these approaches was that the improved catastrophic benefit protection that would be made available to all would only be financed by a minority of the beneficiary population who actually use inpatient services.

Instead, the Council recommends that a new basic part A hospital insurance protection be provided to all beneficiaries based on the payroll or self-employed tax contributions they make during their lifetime. For those who elect only part A hospital insurance, this new benefit would provide unlimited days of inpatient hospital care, 100 days per year of care in a skilled nursing facility, and all of the currently offered home health and hospice benefits.

A per admission hospital inpatient deductible, as currently computed, would apply but for no more than two admissions in a year. Further, a daily coinsurance equal to 3 percent of the deductible, would apply to all days used with the exception of the day of admission when a deductible was collected.

The current 12.5 percent coinsurance on applicable skilled nursing facility days of care would continue to apply.

With this as a basic restructure, the Council further recommends that all beneficiaries who elect medicare part B, supplementary medical insurance—about 95 percent now do—automatically receive, for an additional annual premium, an improved part A benefit.

The improved part A benefit would eliminate liability for the daily 3-percent coinsurance on hospital inpatient days and the 12.5-percent coinsurance on applicable skilled nursing facility days of care. In effect, their cost-sharing liability would be limited to the admission deductible and a maximum of two such deductibles per calendar year.

The added premium, which we estimate would be approximately $98 in 1985, would finance the costs of catastrophic protection and the cost-sharing limits and would also provide additional program revenues that will help to alleviate the growing deficits in the part A trust fund.

Under this plan the improved part A benefit, that is, unlimited days of inpatient hospital care with very limited cost sharing would be supported by the substantial majority of all beneficiaries, not

just those who require and use inpatient hospital services in a given year.

The Council also recommends a plan for providing improved catastrophic protection for part B supplementary medical care expenses. The unpredictable and potentially substantial cost sharing that can occur under part B of the program was a frequently cited concern of beneficiaries at several public hearings that the Council conducted.

Under the Council's plan, the beneficiary electing part B would have the option—it would not be required as part of the part B election—to purchase a supplemental plan that would establish an annual dollar limit—$227 per year in 1985—on their cost-sharing liability for approved medicare part B charges. The premium for this protection, assuming that a substantial percentage of medicare beneficiaries opted for it, would be approximately $150 per year in 1985.

In summary, under the Council's recommended restructure plan, all beneficiaries eligible for part A hospital insurance would receive catastrophic protection. For an additional $98 per year premium in 1985, those beneficiaries enrolling in part B would also be relieved of liability for cost sharing beyond the inpatient deductible.

Beneficiaries, who also elected the optional part B supplement, would also limit their cost-sharing liability under part B. Although such beneficiaries would experience an increase in the medicare premiums they now pay of approximately $250 per year, we believe beneficiaries who supplement their medicare coverage with private medigap insurance, and over 70 percent do so now, will actually realize a net savings in the cost of their health insurance protection. Most medigap policies are priced from $300 to $600 per year with those at the higher end of this range being typical.

The net effect on the part A trust fund of the above recommendations over the next 10 years is estimated to be approximately $38 billion. This includes some $25 billion in additional revenues and $13 billion in reduced expenditures.

Under benefit restructuring, the Council also endorses the concept of voluntary vouchers since it perceives that this would enhance competition in the health care field. However, precautions should be taken to ensure that coverage would be at least as comprehensive as current coverage and that use of the voucher be entirely voluntary. Voluntary vouchers are estimated to cost approximately $50 million to implement.

Also, the Council is recommending that the part B deductible be indexed to the Consumer Price Index. That is, when the Social Security benefits are increased, the part B deductible which is currently $75, would also be increased by the same percentage.

Indexing of the part B deductible would have no impact on the part A trust fund shortfall. However, if begun in 1985, the part B trust fund would realize accumulated savings of approximately $680 million by the end of fiscal year 1989.

A second major group of recommendations of the Council addresses medicare reimbursement policies. The Council endorses the concept of prospective payment and did so prior to the enactment of the Social Security Amendments of 1983.

The Council recommends, however, that the rate of increase in DRG payment be limited to the hospital input price index and not the hospital input price index plus 1 percent, as is currently in the law. It is estimated that restricting the increase in DRG's to the hospital input price index would save some $34.5 billion by 1995.

Another recommendation, which may prove to be controversial, would eliminate medicare's reimbursement for medical and other professional health education expenses incurred by hospitals. It is the belief of the Council that it is inappropriate for a health care program designed to provide care for elderly and disabled Americans to be subsidizing such education expenses.

The Council fully recognizes the importance of medical education and the need for continued Federal support. However, it believes that these costs should be funded through other Federal, State, or local programs and not by the medicare program.

Another major recommendation of the Council which is not expected to generate any savings but is a consequence of the extensive testimony the Council heard throughout the United States concerns medicare's physician assignment policy. The Council is recommending that physicians annually be given the option to either elect to participate or not to participate in the medicare program.

Those physicians who elect to participate would agree to accept medicare payment as payment in full and not bill the beneficiaries for the difference between their charges and what medicare considers reasonable and allowable—customary, prevailing, and reasonable charges.

If a physician does not participate, the medicare payment would be made to the patient who would then be responsible for paying the physician's entire bill. A physician would be given the option to elect to participate; however, he or she could terminate the participation agreement by providing medicare with 180-day notice.

In return for agreement to participate, the Council further recommends that the HCFA publish local directories of participating physicians in every major locality. The directory would identify by medical specialty those physicians who have agreed to participate in the program.

As added incentives medicare would allow for batch billing or subsidized electronic billing by participating physicians and would provide for electronic funds transfer of payments to provide a more predictable cash flow for participating physicians.

Under the category of financing, the Council opposes increasing payroll taxes beyond currently legislated levels to pay for the projected deficit in the medicare trust fund.

However, we do endorse the taxation of a portion of employer-provided health insurance similar to the proposal submitted by the Reagan administration last year. The Council does not view revenue raising as the primary benefit of this proposal.

Rather, Council members believe that over the long run consumers will choose more cost-effective types of care, thus decreasing the overall rate of growth in health care costs.

A majority of the Council also recommends increasing the Federal excise tax on alcohol and tobacco products. Mr. Chairman, you testified before the Council in favor of an increase in the alcohol

and tobacco excise tax with the additional revenue to be earmarked for the hospital insurance trust fund.

The Council's rationale for its recommendation is the increasing evidence that these two products cause significant increases in health care expenditures and if additional revenues are needed, current excise taxes should be increased and earmarked to the hospital insurance trust fund to help solve the medicare shortfall.

Those who opposed such increased excise taxes cited the negative effects on the industries involved and pointed out that this has traditionally been the prerogative of the States as a source of revenue.

In the final analysis, however, the Council believes that some additional source of revenue should be identified and that an increased excise tax is the least objectionable of the available alternatives.

The eligibility recommendations of the Council include perhaps the most controversial recommendation of the Council, advancing the age of eligibility for medicare from age 65 to 67 over the next 5 years. If implemented, this recommendation would produce about $75 billion in medicare savings over the next 10 years.

Since the medicare program began, the average lifespan has increased more than 3 years. This increase in life expectancy has major implications for the medicare program.

As you know, the ratio of workers contributing to the trust funds to beneficiaries collecting benefits continues to decline. The expanding population combined with the increasing longevity of that population places a particularly severe financial burden on medicare as health care costs increase with age.

The Council recognizes that recent changes in the age of eligibility for cash retirement benefits will be implemented over a 40-year period. However, the Council believes to continue to have a viable medicare program, more immediate changes in the age of eligibility for medicare are necessary.

Finally, the Council endorses the concept of advance directives or living wills which are currently recognized by law in 14 States. The Council called for a study to look at the impact on health expenditures in those States having such laws and encouraged other States to adopt similar legislation.

Living wills would prevent unnecessarily heroic, and oftentimes unwarranted, measures being taken in the terminal days of life. Eleven percent of medicare expenditures are spent in the last 40 days of life and some 25 percent of medicare expenditures are incurred by patients in the last year of life.

The Council fully recognizes that this may be a controversial recommendation. However, the Council unanimously endorsed it. As a physician, I initiated Council discussions on this subject having recently lost my father and thus knowing the enormous costs that were incurred in his terminal days prior to death.

The Council recommendations I have just reviewed would, if enacted, eliminate the financial burden of the hospital insurance trust fund. If those recommendations whose savings or revenues have been quantified were to be implemented promptly, the trust fund would be fully solvent in 1995 with a moderate reserve to guard against contingencies.

Those recommendations which have not been quantified represent, in our view, viable alternative sources of revenue in the event of delays or failure to adopt portions of the quantified package.

Mr. Chairman, that covers the highlights of the more significant recommendations of the Council. As you are aware, there are also several others which I will be happy to discuss with you.

I do wish to note that in addition to our formal recommendations the Council did identify several issues which they viewed as deserving of future study by the Department of Health and Human Services. These are spelled out in the Council report and include some suggested alternatives for a longer term restructuring of the medicare program.

Thank you very much.

Chairman JACOBS. Dr. Bowen, we are pleased to have your testimony. We also note you are accompanied today by the Honorable Don Newman of the Governor's office.

The committee is also pleased and honored to receive the testimony of Mr. Arnold, also a member of the Advisory Council, possibly with slightly different views from some of the report.

STATEMENT OF STANFORD ARNOLD, MEMBER, ADVISORY COUNCIL ON SOCIAL SECURITY, SECRETARY-TREASURER, MICHIGAN BUILDING & CONSTRUCTION TRADES COUNCIL, AFL–CIO

Mr. ARNOLD. Thank you, Mr. Chairman.

I am Stan Arnold. I am secretary-treasurer of the Michigan State Building & Construction Trades Council representing the employees' views on the Advisory Council.

I appreciate this opportunity to share with the committee my views and those of my colleague, Alvin Heaps, on the majority report of the medicare Advisory Council. I am appearing here today also to represent the views of the AFL–CIO on the report.

I wish to summarize our concerns about the majority report and offer suggestions for alternatives to permanently solve medicare's funding crisis without reducing benefits or raising taxes. I would also like to state for the record, that from the time the Advisory Council was appointed, Mr. Heaps and I had reservations about the fact that beneficiary groups had been denied official representation.

We do not know whether having representatives of elderly and disabled medicare beneficiaries on the Advisory Council would have changed its final recommendations. But we do know that the concerns of these citizens would have been given greater weight throughout all of the Council's deliberations if they had been given an opportunity to participate.

In general, we believe that the proposals supported by the majority of Council members hold harmless the primary decisionmakers in the health care system, namely doctors and hospitals, while squarely placing the financial burden of corrective action on those who are the least responsible for rising costs and the least able to withstand increases in out-of-pocket payments, elderly and disabled medicare beneficiaries.

Second, we believe that the majority's recommendations, if implemented, will do nothing to prevent the predicted bankruptcy of the medicare trust fund.

While we did vote against many of the Council's final recommendations, there were suggestions put forth by the majority with which we were able to agree, including the statement that eligibility for medicare benefits not be contingent on income. We believe any change in this longstanding policy would violate the very essence of the medicare program and for beneficiaries would act as a cruel and unnecessary barrier to timely and appropriate treatment.

In our statement we commended Dr. Bowen for his hard work chairing the Council and also complimented Mr. Burke, the Executive Director of the Council, and his staff. We do not intend to undermine their efforts by expressing our views on the final recommendations of the Council, but do believe it is necessary to make the committee aware of our dissent on the following seven key issues:

One, we did not support the view held by the majority of Council members that general revenues ought not to be used to fund the medicare program. The so-called "medicare problem" exists in large measure because of the Federal Government's past unwillingness to take the steps necessary to pass a comprehensive cost containment program to control rising health care costs.

We are proposing four recommendations to limit total health care spending, which will be described later in this paper. However, if our recommendations are not implemented in time to save medicare, general revenue contributions should be used to preserve the program and protect its beneficiaries.

Our position on general revenue financing is consistent with the recommendations of previous Social Security Advisory Councils. The alternative, which we believe is unacceptable, would be to drastically cut benefits and/or reduce eligibility.

Two, we opposed placing limits on tax free employer contributions to health insurance to fund the deficit in the medicare program. Proponents of this plan have claimed that the employee health tax proposal is designed to make workers more cost conscious.

In reality, it would result in drastic reductions in coverage for preventive care, outpatient diagnostic services, and other benefits which save money. It would leave intact coverage for hospital and surgical benefits, which have been the chief source of health-cost inflation and costly overutilization, over which patients have little control.

The health tax proposal would also penalize older workers, workers living in high-cost areas and those who select more comprehensive benefits plans, such as health maintenance organizations—HMO's.

Three, we opposed increasing taxes on alcohol and tobacco to increase revenue for medicare. These are regressive taxes which would disproportionately impact the low-income population and unfairly single out particular industries.

We believe that increasing alcohol and tobacco taxes cannot be viewed from the standpoint of medicare alone. There are a number

of negative economic and social effects of such a decision to which the Council has not given sufficient consideration.

Four, we rejected the idea of increasing the medicare part B deductible. We also opposed levying a surcharge on beneficiaries to help finance the deficit in the part A trust fund. Both proposals would shift to the elderly and disabled a larger share of the burden of rising medicare costs, without doing anything to change the behavior of the true decisionmakers in the health care system.

Five, we voted against the proposal to restructure the financing of part A benefits. Although the majority's proposal would entitle benficiaries to catastrophic care, there would, in exchange, be a coinsurance requirement for each day except the first.

We favor including under medicare coverage for catastrophic expenditures, but we oppose requiring the beneficiaries, most of whom are struggling on a fixed income, to bear the brunt of this cost.

Six, we also voted against raising the age of eligibility for medicare from 65 to 67, beginning in 1985. The majority's proposal is inconsistent with the recently enacted social security amendments, which gradually begin raising the age of eligibility for social security benefits after the year 2000.

In addition, we believe that there is little evidence to judge the impact of such an immediate change in eligibility. Only a relatively few individuals over age 65 will be employed in jobs with good health insurance coverage. The rest will be unable to afford to purchase protection on their own.

Seven, we voted against the voluntary voucher proposal. We do not believe beneficiaries would have access to enough information to choose which health insurance policy is best for them.

Furthermore, private insurers have stated publicly that the medicare benefit package would be almost impossible to duplicate at the cost. Insurers would undoubtedly focus their market efforts on healthier beneficiaries, leaving medicare with the highest costs and the worst risks, potentially increasing program costs.

To summarize, we believe the recommendations from the majority of the members of the Social Security Advisory Council, if implemented, would shift to beneficiaries the financial risk of rising program expenditures.

Instead, what is urgently needed is immediate passage of an across-the-board cost-containment program, which would control the rate of growth in private as well as public expenditures. Such a program would close the loopholes in the medicare reimbursement system and prevent the program from going bankrupt.

As an alternative to the recommendations from the majority of the members on the Social Security Advisory Committee, we propose for the committee's consideration the following four point legislative program:

One, enact immediately a comprehensive, across-the-board cost containment system for all payors, public and private.

Two, include in the cost-containment program a mechanism for limiting physicians' fees.

Three, include in the cost-containment program incentives to prevent providers from increasing unwarranted admissions and to limit the rate of growth in capital expenditures.

Four, add to the medicare program a number of initiatives that have been developed in the private sector by labor and management to control the rate of increase in costs without reducing benefits.

We also urge the Department of Health and Human Services [HHS] to release regulations governing the implementation of the provisions of the Tax Equity and Fiscal Responsibility Act [TEFRA], which allow medicare beneficiaries to join HMO's and appropriately reimburse HMO's for these new clients.

Recently, Senator Edward Kennedy and Congressman Richard Gephardt submitted legislation that would accomplish the first three objectives of our plan. Their proposal calls for the enactment of an all-payors cost-containment program to control the rate of increase in hospital costs and physician fees.

It limits reimbursement to providers from all payors, public and private, and strongly encourages States to establish their own cost-containment plans within Federal guidelines. We will continue to work with the sponsors to assure that wages and benefits of nonsupervisory personnel would be protected and that no worker will be displaced as a result of the enactment of this or similar legislation.

We are very encouraged that the actuaries, who have prepared cost estimates on the Kennedy-Gephardt bill, have estimated that, if the legislation is passed in fiscal year 1985 and assuming no increase in payroll taxes, there will be a surplus in the medicare trust fund until 2005, as compared to the projected cumulative deficit of between $200 and $300 billion by 1995.

In addition, such a program could generate savings which would reduce the overall Federal deficit by $30 billion by the end of the decade. It is clear that the time for Congress to act is now.

In addition to the passage of cost-containment legislation, we would also like to recommend that Congress consider improving the efficiency and quality of care associated with the medicare program by adopting some of the changes which have been implemented by labor and management in collective bargaining to reduce rising health care costs without reducing benefits.

These initiatives include preventative health measures; ambulatory surgery; mandatory second surgical opinions and alternative delivery systems, especially group practice HMO's.

We have found that such cost-containment initiatives can reduce health insurance premiums by 30 percent and play a major role in restraining the rate of increase in health care costs without reducing benefits.

For example, RWDSU's department store workers' union in New York City found that once they instituted a mandatory second surgical opinion program, approximately 28 percent of initial recommendations for surgery were not confirmed by second opinions.

We do not have estimates to determine how much these initiatives could reduce medicare program costs, but based on the experience in the private sector, we are confident these programs could reduce the rate of increase in medicare costs and significantly improve the quality of care.

We believe our program offers Members of Congress and the executive branch a practical and equitable approach for improving

the efficiency of the medicare program and substantially reducing program expenditures without harming beneficiaries.

Our proposals provide strong financial incentives for the providers and suppliers of health care services to reduce unnecessary costs without increasing the already heavy financial burden on elderly and disabled medicare beneficiaries, many who have been the chief victims of health care inflation.

We must guard against measures which would reduce the quality of health care or limit access to health care services for the elderly, the poor, and jobless workers.

Mr. Chairman, I appreciate the opportunity to appear here today and express our views, and I hope that Congress gives our views full consideration.

Thank you very much.

Chairman JACOBS. I am sure that will be the case, Mr. Arnold.

Mr. Duncan.

Mr. DUNCAN. Thank you, Mr. Chairman.

I want to thank the panel. It has been very good.

Dr. Bowen, one of the recommendations of the Advisory Council would essentially put the medicare program in the business of providing optional supplemental insurance to replace the so-called medigap policies offered by private insurers.

Do you think that medicare can do a better job than the private health insurers with regard to the medigap insurance?

Dr. BOWEN. I think that is a pretty difficult question to answer. There is nothing in our recommendations that forces that; the option to purchase medigap insurance would still be present and it would be a choice that they would make.

However, the recipient would need to accept part B of the program if he were to benefit from our recommendations. Part B continues to be an optional program.

But as we stated in our testimony, the total bill for the patient would undoubtedly be less than with the present system, because of the purchasing of medigap insurance which ranges usually from about $300 to $600 a year.

And for an increased premium of about $250 a year, you could get the improved package of medicare and be some dollars ahead.

Mr. DUNCAN. Mr. Arnold, as part of the cost-containment system you are advocating, you mentioned limiting physicians' fees. Would you also recommend limiting wage increases across the board in hospitals, administrators, and all employees?

Mr. ARNOLD. If they were as out of line as far as I think some of the doctors' fees are, yes.

Mr. DUNCAN. When we had hearings on this subject a few years ago, one of the problems we ran into was that various organizations did not want to freeze the portion of the system that affected them. As a result, I recall that only about half of the total cost of hospitalization would have been controlled by the legislation under consideration at that time.

Mr. ARNOLD. Congressman, I think that really what we are after, we don't want the cost containment to come out of the hides of the workers that are working now in many cases for $10,000, $12,000 a year. We had the head of the nurses association testify before the

committee, and I asked her specifically what the wages of a nurse was.

And I was surprised to learn that they start around $15,000 to $16,000 and cannot go above $25,000, $27,000, except in very extenuating cases.

As far as I am concerned, the nurses profession is way underpaid, which is all part of this.

Mr. DUNCAN. That was the problem we ran into. And I grant you that some of them are underpaid. But that was one of the problems that we ran into during earlier consideration of the cost-containment problem. Hospital personnel did not want a freeze on that part of the hospital costs, which was, and is, a major part of the total hospital bill.

Dr. Bowen, apparently 7 of the 13 members of the Advisory Council were satisfied on the alcohol and tobacco excess-care costs. What study or studies did you use to establish that conclusion?

Dr. BOWEN. I am not sure I can give you the absolute names of the people and the places from which they did their study. But that will all be submitted in the record.

As I recall, there were a couple of professors from Johns Hopkins, and I believe even from Harvard and from Rutgers that testified that tobacco users, not even abusers, but users were hospitalized and required more medical services than those who did not use it.

Mr. DUNCAN. My question was in regard to medicare beneficiaries, not the public as a whole—medicare beneficiaries. What statistics did you have for that?

Dr. BOWEN. The same thing would apply, if they are medicare beneficiaries and have abused and used tobacco any period of time, and abused alcohol, the costs were much greater than in those who never did or did not spend time utilizing them.

Mr. DUNCAN. What is the cost to the medicare program of treating drinking-related and smoking-related illnesses?

Dr. BOWEN. That will all be submitted in the record.

Mr. DUNCAN. But it wasn't at your hearing. You didn't have that information available.

Dr. BOWEN. Yes, the information was there.

Mr. DUNCAN. I have a quotation from a transcript of May 25, 1983, of your council which says on pages 380 and 386, by Ms. Peres, "Are you talking about how much is spent on the older-age group, or death and illness related to smoking tobacco." And Ms. Aiken said, "Right". She said, "If these figures are available, we want them."

And Mr. Burke said, "I just don't think it exists. I don't think we have the data."

And Ms. Flynn said, "The AMA is sending what they have on tobacco. They don't have a lot, but it's on its way."

Ms. Aiken said, "The Surgeon General's Office doesn't have anything on this use of tobacco. If the staff will touch base with the National Center for Health Statistics and see if anyone there is doing this, I find it hard to think they are not."

It is in the transcript.

Dr. BOWEN. Mr. Congressman, as you said, that was in May, and that was early in our discussion. I believe later, in July or August,

at the meetings we had a lot of material that was submitted giving the estimates of costs.

Mr. DUNCAN. I think the National Journal in an article alluded to the use of sugar, since overweight people have more severe medical problems. Do you think we should put an extra tax on sugar?

Dr. BOWEN. I think that is one of the most logical complaints of advising, recommending increased taxes on alcohol and tobacco, that there are a lot of things that cause some detriment to one's health. Automobiles, motor vehicles, butter, sugar, overweight, and so forth.

But the least objectionable of all of these were the alcohol and tobacco. We ended up voting for things we disliked the least.

There are hardly any of the recommendations that anyone liked. We were given a charge to try to come up with recommendations to, in quotes, rescue the ailing program. And we found out we had to swallow pretty hard to vote for some of the things we did.

But medicare and social security are certainly sacred terms to the elderly, and have proved to be successful programs, and if it is not rescued, then it goes down the drain forever.

Mr. DUNCAN. You had testimony from the Governors who indicated they were opposed to Federal tax increase on tobacco, because that was the prerogative they thought should be left to the States; is that correct?

Dr. BOWEN. Yes, sir. That came in after the vote. However, I doubt that it would have changed the vote.

Mr. DUNCAN. But they did express their opposition.

Dr. BOWEN. Yes, sir. And as a past Governor, had I still been Governor, I would have expressed the same complaint. However, the proportion of income or revenue to the various States as a result of tobacco and alcohol taxes has been greatly reduced over the past several years, so that it is less a detriment, less a fault than what it would have been a few years ago.

Mr. DUNCAN. Reports of the Health Care Financing Administration have suggested that excess hospitalization costs under medicare are more a function of geographical location, race, and economic status than other factors. According to their report, the average hospitalization costs for medicare patients in the eastern region of the country is about one-third higher than in the Southland, and the average hospitalization costs for nonwhites is 20 percent higher than for whites.

So if the plan of charging groups of people on the basis of cost of treatment is adopted, do you think we should perhaps charge easterners just a little more than southerners, and nonwhites a little less than whites?

Dr. BOWEN. No, that was dealt with in one of our recommendations, I believe, when we considered the development of fee schedules, although that was more for physicians than hospitals, because the DRG we think is going to take care of the hospital rates.

But we are aware of greater—an increased number of people admitted per 100,000 people in one area of the country than another, and the length of stay in a hospital is greater in one area of the country than another.

And the fee schedule varies so much. We agree there should be more standardization.

Mr. DUNCAN. Did you look into the indemnification of physicians? We understand and get a lot of information that there is a lot of defensive medicine being practiced. That perhaps if we could find some mechanism to indemnify physicians and health care providers against malpractice suits, there might be a lot of money saved.

Dr. BOWEN. In my judgment that is one of the causes of increased cost of medical care. And that is the fact that you must practice defensive medicine to avoid the chances of suits. And it is unbelievable the high cost of malpractice insurance. It is my understanding that in New York City a neurosurgeon has to spend $60,000 a year just for his malpractice insurance.

And this of necessity causes the rates to be considerably higher.

Mr. DUNCAN. What would be your thoughts on indemnifying doctors against malpractice through some mechanism?

Mr. ARNOLD. I think that something could be worked out, and I think they should have some protection against malpractice.

Dr. BOWEN. I really think it should be a State-by-State solution rather than a Federal solution, however. We in Indiana have one of the best malpractice laws in the Nation where there is a limitation on the amount for which one can sue, a limitation on the time between the alleged malpractice act and the bringing of the suit. The combination of those two things has kept the rates down much better there than in many of the other States.

Mr. DUNCAN. One of the recommendations of your Council is to establish in medicare the concept of participating and nonparticipating physicians. Are you recommending a plan similar to the longstanding approach used by Blue Shield?

Dr. BOWEN. I think it is essentially that, yes. We state that we feel the physicians should have the opportunity either to participate entirely or not at all, but they would have the option of coming in or out of the program with 180-day notice.

The present system is that they can accept assignment on a case-by-case basis, and our suggestion is that it be on an all-or-none basis.

Mr. DUNCAN. Mr. Arnold, your views?

Mr. ARNOLD. I feel all doctors should be participants.

Mr. DUNCAN. Thank you very much.

Chairman JACOBS. Mr. Gradison will inquire.

Mr. GRADISON. Thank you, Mr. Chairman.

I want to thank you for your courtesy in permitting a nonmember of the subcommittee to join the subcommittee today.

The DRG's have been in effect since the 1st of October and are being phased in over a 3-year period. They are the subject of a considerable controversy and many call for modifying the way in which they are applied. Any thoughts as to whether the DRG system can really be made workable on a nationwide basis, or are there fundamental problems within the DRG's which may lead to its early demise as a system for reimbursement?

Dr. BOWEN. I suspect there are fundamental problems in it, but I don't think that there are problems that cannot be solved. At first I thought that the bringing on the DRG program was just going to be evolutionary change, but really it is a revolutionary change.

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I think already it has had considerable effect on the fewer admissions to the hospitals. You are still in the shakedown period and will be for some time yet and I suspect there will be some hospitals that will fall by the wayside as a result of it, but again, the medicine has to be kind of bitter sometimes for the proper results.

Mr. GRADISON. Mr. Arnold, I noted that as the seventh of your objections to the majority's recommendations, you voted against the voluntary voucher proposal. You also called for prompt action by the Department of Health and Human Services in implementing a voucher proposal which was supported by this committee and included in the medicare changes that were made in 1982, specifically, the opportunity on a voluntary basis to use a medicare voucher to join a HMO.

I would like to understand your thinking with regard to vouchers in general and the use of vouchers for HMO's in particular.

Mr. ARNOLD. I think there is a difference in the individual going out and shopping for insurance coverage and the use of the voucher in the HMO's.

I just do not think that there is enough information or the individual would have enough information out there to decide which is the best program for him, or the best insurance program, on the voucher system that was proposed by the Council.

Mr. GRADISON. There could be more than one HMO in a given community that would be competing for the voucher under the HMO TEFRA provision, and it would be a voluntary matter, but the elderly beneficiary could decide to continue on the present reimbursement system or to exchange the voucher for care from any number of HMO's which might happen to be available.

It seems to me that some degree of consumer choice would be required, even under the present voucher system, that is, the HMO voucher that is on the books.

That is why I am pursuing this matter.

Mr. ARNOLD. I think the HMO's are better organized and federally approved.

I don't think there would be as much confusion picking an HMO as to what, for me, for instance, trying to go out and select a health-care carrier in my place.

Mr. GRADISON. Thank you. That is very helpful.

Chairman JACOBS. On the recommendation of the Commission with respect to assignment in part B of medicare, I am told that organizations representing retired people have apprehensions about that proposal, which I think could be fairly characterized as all or nothing during a year's period.

They think that it is more likely to be nothing at all. Do you have any opinion about that?

In other words, if I may add to the question, for elucidation purposes, we had a witness from the AMA a few months ago say in his own practice, when he picked and chose among patients for whom he would accept assignment and not, he pretty much went according to what the traffic would bear.

He would accept the assignment where he was dealing with an "empty pocketbook" whereas he would not when he was dealing with a "full-blooded" pocketbook. I would like, really, if both of you would comment on that in turn.

Dr. BOWEN. In our hearings, I suspect this was the topic on which our senior citizens were the most adamant. They were downright mad, really, that the physicians were not accepting assignments, because that left them up in the air as to what their final bills would be, and they could not plan adequately for it.

The physician assignment recommendation we have, I don't believe, would save any money at all for the program but it would be helpful in saving for the senior citizen.

I believe that about 50 percent now accept assignment, 51.2 or 51.3. I think that, as time goes on, more will go on assignment rather than fewer and it may be related to the fact that there are more physicians coming on line at the present time, more competition and perhaps more desire to accept assignment.

I think also that the incentives that are recommended for accepting assignment will be helpful, that is, mass billing and electronic transfers for more rapid payment and so forth.

I think that the doctors in general are opposed to this, and I can see their side of it very much.

Chairman JACOBS. I bet you can.

Dr. BOWEN. Were I not on the committee, I might have the same opinion, but we were given a job to do. As I say, we have voted for the things that we dislike the least.

I support this.

Chairman JACOBS. Mr. Arnold.

Mr. ARNOLD. Mr. Chairman, I think that many of the aged groups that I talk to fear that they are not going to get the right kind of care if a doctor is forced into taking assignments, but I think, as the doctor said, the competition is going to be out there and the care is going to be there. It is unfounded, as far as we are concerned.

Chairman JACOBS. Any omitted questions?

Any further testimony in chief?

Mr. DUNCAN. Mr. Chairman, I would like to ask permission that we may submit questions for answering in writing.

Chairman JACOBS. Would the witnesses be so kind as to respond to questions subsequently?

Dr. BOWEN. We would be happy to.

Chairman JACOBS. We would be most grateful.

[The information follows:]

RESPONSES FOR THE RECORD TO QUESTIONS SUBMITTED BY CONGRESSMAN DUNCAN OF THE WAYS AND MEANS SUBCOMMITTEE ON HEALTH

Question 1. "The Insurance Economics Society has charged that such Medicare enhancement of benefit and increase in "Part B contributions" is tantamount to a government takeover of a substantial block of the private insurance business generally known as "Medigap" insurance.

"Is the charge true, that in this proposal, the government would take over the private Medigap insurance coverage of 3 out of 4 Medicare beneficiaries, amounting to 15 million people now covered by private insurance carriers, Blue Cross or organization plans such as that offered by the American Association of Retired People (AARP)"?

Answer. Use of the term "takeover" is perhaps an overstatement implying that should the Council's restructure plan be implemented, private insurors would be precluded from engaging in the health insurance business with respect to Medicare eligibles. It is important to note that the enhanced benefits recommended under both Part A and Part B of the Medicare program are voluntary. However, the Part A hospital and SNF benefit enhancement is proposed to be offered as an integral

part of the Part B SMI option, i.e., if a beneficiary wishes to have basic Part B insurance he is automatically enrolled for the Part A enhancement plan and would be charged the premium. Therefore, since the basic Part B medical insurance plan of Medicare is generally considered to be a wise investment for the aged, especially because its cost is heavily subsidized by the government, the likelihood is that few would fail to elect such coverage. This linkage of the Part A hospital insurance enhancement with the Part B election was considered necessary to preclude adverse selection where only those in poor health and anticipating unusual use of hospital inpatient care would select the Part A enhanced coverage.

The Part B enhancement is, however, not linked in any way to other coverage. An individual may elect the added Part B protection or not elect it. Non-election of this option would not result in the loss of any of the basic Medicare protection offered.

If a majority of beneficiaries continue to elect the basic supplementary medical insurance protection of Part B and, therefore, the enhanced Part A protections, the need for private insurance to supplement Medicare Part A to provide catastrophic coverage would be substantially reduced. The inpatient hospital deductible, limited to two per year, would be the beneficiary's only potential liability, It is possible that with respect to Part A many beneficiaries will consider their potential liability low enough to forego insuring privately to cover it.

Similarly, the optional part B enhancement would reduce the amount of supplemental coverage needed for those services covered under Part B. However, private insurance could continue to offer policies which cover the remaining Medicare Part B cost-sharing or supplemental benefits such as outpatient drugs, eyeglasses and/or hearing aids which many beneficiaries would find appealing. Additionally, if comparable coverage were available privately at less premium cost, beneficiaries would be free to select such coverage and reject the Medicare offering.

There is no question that should the Council's restructure plan be implemented private "Medigap" insurors would no longer have the same market for the current Medigap policies they now offer. However, modifications of their policies to meet whatever gaps in Medicare coverage remain for individual beneficiaries under the restructured Medicare benefit and to provide additional coverages not included in Medicare would offer a market for such insurors.

Question 2. "The Council's Report states the government can do it cheaper than the private sector in the statement that the new enhanced Medicare benefits "will be improved and at less cost than comparable Medigap/Medicare protection."

"Yet the eminent Actuary, Robert J. Myers disagrees. He testified before the Council that "in order to give the enrollees high quality service, a vast network of Medicare field offices would have to be established."

"Is this assessment of Mr. Myers' true, and if so, has the magnitude of establishing Medicare Information Centers been estimated by the Council and is this estimate reflected in the allegation that Medicare can do the job at less cost than the private sector?"

Answer. The Medicare Part A benefit package that would be offered under the Council's restructure recommendation would be "improved" because under Part A it would provide unlimited days of inpatient hospital care and would limit cost-sharing to no more than two inpatient deductibles per year. Under Part B, if the enhancement option were selected, it would limit cost-sharing liability to a specific and thus more predictable dollar amount each year. The proposed enhancements are viewed as "less costly" than comparable protection that is today offered through a combination of basic Medicare and private Medigap insurance. No claim is made by the Council that the government is somehow inherently more efficient in delivering the service than the private sector. Rather, the expected savings are the result of expanding the existing basic Medicare structure to provide the additional benefits as contrasted to providing the same through numerous separate benefit structures developed and administered by private insurors.

Today many private insurance companies market policies designed to cover Medicare copayments and/or services such as prescription drugs which are excluded from Medicare coverage. This necessarily requires that the companies incur costs for marketing, and administering such policies, costs which become part of the premium for the supplemental policy.

Of course, the government incurs some of these same costs but offering expanded protection does not add substantially to costs already incurred in providing these same services under the current Medicare program plan. For example, a premium collection system is already in place and adding amounts to be collected would not produce greatly increased costs. With respect to claims processing costs the same claim currently processed would be adjudicated based on the expanded coverage being offered, e.g., instead of deducting a given copayment amount from a payment

to a provider, a higher amount would be paid. This contrasts with the need for a separate claim and claims process generally required by the Medigap insuror to pay these supplemental benefits.

Contrary to Mr. Myers' contention, we see no need to establish a separate network of information centers around the country to service beneficiaries because of this recommendation. Social Security district offices currently provide basic Medicare information and would continue to do so under the restructured plan. Any need to improve information services to beneficiaries, (the Council has separately addressed their concern on this matter in the final report) would not be the result of the Council's restructure proposal.

The Part A hospital insurance changes recommended should result in a greatly simplified benefit easier to explain and easier to understand. Today beneficiaries must be informed of the "benefit period" concept, the limitations on days of care available, the different coinsurance rates that apply depending on the amount of utilization, the lifetime reserve day provision, etc. Under the restructured Part A plan these complex features are eliminated and the principal item of interest would be the inpatient deductible, how much it is and when it applies.

With respect to the Part B optional insurance, the beneficiary would have to be provided information concerning what it provides and what it costs in order to make a decision as to whether to elect or not elect the additional protection. Since the Part B enhancement is essentially a cost share dollar limit benefit it should not be a complex one to explain.

Question 3. "Under the Advisory Council's recommendation, the election (1) to keep Medicare Part A, or (2) to take Enhanced Part A or 3) Enhanced Part B is purely voluntary.

"Is it correct to presume that the federal government is to assume the role of an insurance competitor for the private Medigap insurance market that currently insures 15 million Medicare beneficiaries?"

Answer. Since both the Parts A and B enhancements are voluntary (see explanation of linkage of Part A enhancement with the basic Part B (SMI) election) and beneficiaries could choose either the Medicare offering or the revised basic Medicare benefit with private supplemental insurance, competition between the government and private insurors would be present.

Question 4. "In a Western Union Nightletter dated October 28, 1983, delivered to each member of the Council, the Insurance Economic Society charged that 'the transcript of the Council's proceedings for October 16, 1983' raises a very serious misimpression concerning commissions paid to agents."

"Further, in testimony presented to the Council by Randy Freudig, president of the National Association of Health Underwriters, August 24, 1983, it was stated: "long ago, health insurance agents agreed to accept substantially reduced commissions on the sale of Medigap policies . . . "even though". . . it requires considerably more time to explain to the elderly the benefits and gaps in Medicare."

"Is it correct to assume that the erroneous charges of high agent's commissions the Council heard in the proceedings on October 16, 1983 were corrected by the results of the telephone survey of Medigap insurance companies detailed in the October 28 Western Union Nightletter sent to each member of the Advisory Council by the Insurance Economics Society?"

Answer. The issue of the rate of commissions of agents selling Medigap insurance was not a factor in the Council's decision regarding the restructure plan. The Council did not investigate specific cost components of Medigap policies but rather reviewed information about typical Medigap policies and premiums charged for such policies. The Council was aware of the wide variety of supplemental plans available and recognized that the costs of such plans vary by geographic area, coverages provided, age of the policyholder, etc. However, the typical policy meeting minimum government standards and not offering extensive additional benefits such as drug coverage or extended nursing home benefits, involves a yearly premium higher than the estimated premium under the restructure plan. Additional, many charge higher premiums as the age of the policyholder increases.

During the October 16 meeting one Council member shared information he had received from private sources questioning the appropriateness of commissions charged by some Medigap insurors. The member suggested a further evaluation of the matter. However, when it was clarified that the Council had already approved the restructure approach the matter was not discussed further at this or any subsequent meeting. While individual members were not polled, it is assumed that any misinterpretations about Medigap commissions that may have occurred were clarified by the Insurance Economic Society October 28, 1983 nightletter. However, the important point is that the issue was not a factor in the Council's decision on this issue.

Question 5. "The Council has recommended a Surcharge of $42 per year be exacted from each Medicare beneficiary who elects the proposed Enhanced Part A or Enhanced Part B in order to build up reserves for Health Insurance Trust Fund.

"Would those Medicare beneficiaries who elect to remain with the original Part A escape this Surcharge or $42 per year? Would this exemption be discriminatory against those who elect Enhanced Medicare?"

Answer. It is correct that those who chose not to elect Part B (SMI) and the enhanced Part A benefit would not pay the premium charge and thus would not pay that portion of the premium devoted to revenue raising. However, it should be noted that one factor in the Council's determination to add a revenue factor to the premium was to share in savings that beneficiaries who chose the enhanced benefit would realize because of the reduced need to purchase more costly supplemental "Medigap" insurance. Those who chose to stay with only the basic Part A plan would have to pay generally higher premiums for supplemental coverage and thus would not realize those anticipated savings.

Aside from this, the Council's concern was that any additional cost sharing and-or contribution to the trust fund by beneficiaries, beyond their payroll tax contributions, should be shared as equitably as possible. Under other approaches such as increased coinsurance, only those beneficiaries using services in a year (a minority of the beneficiary population) would be contributing. Although under the restructure plan of the Council some may choose to be excluded, we expect that the number would be very small, and there would be a far more equitable distribution of the liability for both additional benefits available and revenue contributions.

Question 6. "Currently, Medicare Part B funding is heavily subsidized (about 75%) by General Revenues."

"What is the percentage of government subsidy that has been calculated in addition to the Advisory Council's cost estimates for the proposed Enhanced Part B "premiums."

"Does the percentage of government subsidy differ from the current Part B?

"Is the enhanced Part B government subsidy included in the cost comparisons calculations that led to the Report's statement: "the benefits offered (by the government) will be improved and at less cost than comparable Medicare/Medigap protection (provided by private insurance)?"

Answer. The proposed premiums for the enhanced Part A benefit and the enhanced Part B benefit *include no subsidization by the government.* For example, the estimated 1985 premiums for the Part A and B enhancements, $56.50 and $150.00 respectively, represent the estimated cost of providing the additional benefits in that year, i.e., cost of daily inpatient coinsurance and cost of Part B coinsurance in excess of annual dollar limit. Similarly, the additional premium for added revenue, $46, would not be subsidized.

Chairman JACOBS. We express our appreciation for the excellent work of the Advisory Council. The fact that there is a minority report indicates that there is a lot of life in the Council, and that is all to the good.

We will take into careful consideration the recommendations and we are grateful for your testimony today and for the work you did.

The hearing is adjourned.

[Whereupon, at 11:10 a.m., the subcommittee adjourned, subject to the call of the Chair.]

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